ND RYAN WHITE PROGRAM PART B RE-ENROLLMENT APPLICATION
NORTH DAKOTA DEPARTMENT OF HEALTH
DIVISION OF DISEASE CONTROL
SFN 58583 (Rev. 02-2018)

The following information is requested to determine if you continue to qualify for North Dakota Ryan White Program Part B. The law does not require that you provide the information. However, without this information we may be unable to determine your eligibility for assistance or help you with appropriate referrals.

It is against the law for you to provide information that is not true. If you do, you may be charged with a crime.

All the information you provide is private and confidential. Only those people who need the information to do their jobs will see your information. These people are the North Dakota Ryan White Program Part B staff, program auditors, private health insurance plans, your medical care providers, your case manager, and any advocate you may list on this application. We will ask your permission for anyone else to see the information you give us.

Items you will need to provide:

- ☐ **Residence**: Bring records to show where you live (rent receipts, utility bills, etc.).
- ☐ **Health insurance**: Bring explanation of any change in benefits since initial enrollment period.
- ☐ **Income**: Bring records to show your gross income (wage stubs, SSDI, SSI, tax forms, etc.).
- ☐ **Program Verification:** You may be asked to provide acceptance or denial letters from other programs that you have been asked to apply for such as Medicaid and Medicare**.**

When you complete this application:

- Answer all questions completely.
- Review the form to make sure you have answered all the questions you can.
- Sign and date where indicated and return the form to your case manager along with the items listed above.

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ND Ryan White Case Management Site	ND Ryan White Client Number	ND ADAP Client Number

Applicant's Information

Name of Applicant		Date of Birth		
Street Address		City	State	ZIP Code
Mailing Address (if different)		City	State	ZIP Code
Primary Telephone Number	Secondary Telephone Number	Email Address		
Physician's Name	Clinic	Pharmacy		
Emergency Contact's Name	Telephone Number	Relationship		

Employment Status
☐ Employed full-time ☐ Employed part-time ☐ Unemployed ☐ Disabled ☐ Retired

Assistance Requested

☐ Case management (all clients eligible)
☐ Health care (medical, oral) payment assistance
☐ No change in assistance needed
☐ AIDS Drug Assistance Program (ADAP)
☐ Housing assistance and supportive services
☐ Other _____

Insurance Information

Select all the policies that you have and attach a copy of the front and back of the card.

☐ Medicaid (Traditional) ☐ Medicaid Expansion
☐ Medicare Part A/B ☐ Medicare Part D ☐ Medicare Supplemental
☐ Private employer ☐ Private Individual ☐ VA, Other Military ☐ IHS
☐ Other (specify): _____

Policy Carrier:_____ Policy Number:_____ Start Date: _____

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Are you receiving premium assistance through Ryan White? ☐ Yes ☐ No

☐ **No insurance***

If uninsured, please briefly explain why you are not enrolled in, or do not qualify, for health coverage.

_____

_____

If employed, does your employer offer health insurance? ☐ Yes ☐ No

Household Characteristics and Income

My living situation is: ☐ Stable/Permanent, please specify: ☐ Rent ☐ Own
☐ Temporary (transitional housing for homeless, staying with friends or family)
☐ Unstable (homeless: shelter, vehicle, transitional housing, streets, jail)

Household/family size: _____

What is your yearly gross (income made before taxes) household income?_____

Please include W2s or one month of pay stubs with this application for all household members related to you by blood, marriage or adoption. If you are unemployed and/or did not file taxes, please complete the box below.

☐ I did not file income tax in 20_____. This statement is true to the best of my knowledge.
☐ I currently have no income and have not received income since _____.

Screening Assessment

Tobacco Screening

Are you a tobacco user?	☐ Yes	☐ No	☐ Former User
Are you interested in quitting at this time?	☐ Yes	☐ No	
Are you exposed to second-hand smoke?	☐ Yes	☐ No	
Referral offered:	☐ Yes	☐ No	

Recommended Annual Screenings for HIV-Positive Persons

Have you been screened for ***syphilis*** in the past 12 months?
☐ Yes, date tested:_____ ☐ No ☐ Not medically indicated (not sexually active)

Have you been screened for ***chlamydia and gonorrhea*** in the past 12 months?
☐ Yes, date tested:_____ ☐ No ☐ Not medically indicated (not sexually active)

Are you currently pregnant? ☐ Yes, estimated delivery date _____ ☐ No ☐ Not applicable

Have you received cervical cancer screening (Pap smear) in the past 12 months?
☐ Yes, date_____ ☐ No ☐ Not applicable

To Be Completed by Case Manager

Please select whether you provided screening and counseling for the following:

HIV transmission risk	☐ Yes	☐ No	☐ Not medically indicated
Mental health screening	☐ Yes	☐ No	☐ Not medically indicated
Substance abuse screening	☐ Yes	☐ No	☐ Not medically indicated

Certification

I hereby certify that the representation of my income, insurance and other financial assistance is a true and accurate statement and that eligibility requirements as listed above have been met and documented. I also certify that any increases in income, insurance or other financial assistance will immediately be reported to my case manager. I understand re-enrollment on an annual basis is required. I understand that I must **re-enroll each April** and **recertify each October**, and if I fail to do so, I will **become ineligible to receive ND Ryan White Program services.**

Client/Guardian Signature_____ Date _____

Case Manager Signature _____ Date _____